C.O.B.R.A. CONTINUATION OF HEALTH BENEFITS ELECTION FORM

Employer Plan: **Navajo Nation Employee Benefits Plan**
Plan Number: **710000**

Location Number:

Participant Name:

Member ID#: 0000000000

Date coverage terminated:

Date of Notification of COBRA Rights:

Correspondence Address:
HMA, INC.
1600 West Broadway Road, Suite 300
Tempe, AZ 85282
(888) 811-8944

To continue benefit coverage under the group health plan administered by HMA, INC., you must complete Section 2 and 3 and return to HMA, INC. If you decline coverage, complete Section 1 only and return to HMA, INC.

1. NO, I DO NOT WISH TO CONTINUE MY COVERAGE

Signature _____ Date _____

2. YES, I WISH TO CONTINUE COVERAGE FOR: (Check 1, 2, or 3 below)

- ☐ Self
- ☐ Self and my eligible dependent(s) listed below
- ☐ Only my eligible dependent(s) listed below (Applies to Section 5 only)

NOTE: YOU OR YOUR DEPENDENT(S) MAY CONTINUE COVERAGE ONLY IF COVERED UNDER YOUR GROUP HEALTH PLAN ON THE DAY PRIOR TO YOUR QUALIFYING EVENT.

Dependent(s) to be covered: (**Please PRINT**)

Name	Relationship	Date of Birth	Social Security Number

BENEFITS ELECTED: Medical/Dental/Vision
MONTHLY PREMIUMS ELECTED: (Effective 01/01/2009)

Individual Only: $123.45 Family: $309.40

3. YES, I WISH TO CONTINUE MY COVERAGE AS DESCRIBED ABOVE

Signature _____ Date _____

( ) -

Telephone Number

Street Address City State Zip Code

C.O.B.R.A. ELECTION FORM (Continued)

QUALIFYING EVENTS
(Please Check Appropriate Box)

4. 18 MONTHS

☐ Employee terminated employment because of voluntary termination, unapproved leave of absence, laid off or was dismissed for reasons other than gross misconduct

☐ Reduction in hours

☐ Retirement

5. 29 MONTHS

☐ Totally disabled as determined under Title II or XVI of the Social Security Act

(Only if the Plan Administrator is notified within 60 days of the date of Social Security Administration's determination and prior to the end of the 18 months of Continuation Coverage)

6. 36 MONTHS

☐ Divorce or Legal Separation

☐ Covered Employee's Entitlement to Medicare

☐ Loss of dependent status (reached age of eligibility under the Plan)

☐ Death of covered employee

*** IMPORTANT***

THIS NOTICE MUST BE MAILED TO HMA, INC. WITHIN 60 DAYS OF RECEIPT OR YOU WILL FOREFEIT YOUR RIGHT TO CONTINUE YOUR HEALTH BENEFIT COVERAGE AND YOU WILL NOT HAVE ANOTHER OPPORTUNITY TO ELECT COVERAGE.

**** PLEASE MAKE CHECKS PAYABLE TO N.N.E.B.P.****

Send completed form to:

HMA, INC.
1600 W. Broadway Rd., #300
Tempe, AZ 85282